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ABSTRACT

Issues are presented which concern today's children, even those growing up under the best of environmental, social, and economic conditions. All will face an increased probability of emotional stress accompanying problems of living, undoubtedly resulting in increased demands upon child mental health services. The history of child mental health services and delivery systems, the collaboration between community mental health clinics (CMHC's) and public schools at various levels of intervention (individual and group), and problems facing CMHC's and schools in the area of mental health services are reviewed. Three prototypic models for delivery of CMHC child mental health services through collaboration with public schools are described in detail, including a school-based model, an adaptively-based model, and a clinic-based model. (Author/HLM)

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Collaboration between Child Mental Health Services and Public Schools

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During World War II, American sociologists observed the United States was a society in which technological advances had far outstripped advances in human and social management (Mannheim, 1940, pp. 39-75). Sociologists also suggested the latter half of the 20th century would be characterized by anomie, alienation, and social disruption.

As we stand midway through that half century, it seems those pronouncements were quite accurate. Our technological needs increasingly involve a smaller, but more skilled work force. As the range of economic roles narrows, the toleracne for social deviance also narrows. Lemert (1967, pp. 40-70) suggests that when definitions of socially acceptable behavior narrow, more people are labelled as deviants and more people accept deviancy as a way of life.

Today's children, even those growing up under the best of environmental, social and economic conditions, will face increased probability of experiencing emotional stress accompanying problems of living. This intensification in the frequency and quality of such stress will undoubtedly result in increased demands upon child mental health service. The response of these services to such demands can be viewed as an extension of their historical and contemporary histories.

Historical Analysis of Child Mental Health

The history of child mental health exemplies a pattern common to most social services. Services and delivery systems reflect an era's prevailing social ideology and are embedded in the social and economic conditions of the times (Deutsch, 1950; Grob, 1966, Hetznecker & Forman, 1971; Levine & Levine 1970; Platt, 1969).

The latter part of the 19th century was an era of enormous social change involving industralization, immigration, migration, and urbanization. The effects of such processes on children spurred the founding of rehabilitative juvenile institutions and enactment of juvenile codes of law (Nyquist, 1960, p. 140; Winslow, 1968, p. 199). Other child initiatives of this era included the first White House Conference for Children, establishment of the U.S. Children's Bureau, and the establishment of the first demonstration child guidance clinics (Hetznecker & Forman, 1971; Levine & Levine, 1970; Noshpitz, 1974).

In contrast, the 1930's and 1940's were eras in which economic and international issues predominated. In response to primarily economic considerations, public policies for children were incorporated into Roosevelt's New Deal responses. These included the National Youth Administration, the Social Security Act of 1935, and the child labor laws of 1936 and 1938 (Bremner, 1974, pp. 1987-2000). However with the U.S.'s entry into WW II, child concerns assumed minor importance. Consequently, when Congress enacted the National Mental Health Act in 1946, no specific mention was made of child mental health services (Bremner, pp. 1472-1474

The current policy thrust in child mental health was heralded by the Supreme Court's 1954 Brown vs. Topeka Board of Education decision regarding segreagation of schools. This decision was strongly influenced by social science research. Consequently environmental and developmental theories gained greater ascendancey (Noshpitz, 1974).

In 1955, Congress passed the first Mental Health Study Act and established the Joint Commission on Mental Illness and Mental Health. In 1961,

the Joint Commission issued its report recommending establishment of community mental health clinics including intensive psychotherapy, medical and social treatment procedures for children (Bremner, p. 1498). However the 1963 Mental Health Centers Act emphasized treatment for adults, and requested states to submit comprehensive state mental health plans. Nineteen plans failed to include child services as a specialized area. Only 13 plans discussed the prevention of childhood mental illness. Only three plans mentioned public school mental health programs (Glasscote, Fishman & Sonis, 1972, p. 2).

As the 1960's progressed, the effects of social change increased in visibility, punctuated by assasinations, demonstrations, and urban riots. Such visability influenced Congressional authorization of the Joint Commission on Mental Health of Children (JCMHC). In its final report, JCMHC (1970) recommended a child advocacy system consisting of child-focused organizations on the national, state, and local levels. The JCMHC report also emphasized the need for governmental leadership and support of child-centered services, and the enormous impact which institutions and their arrangements have on children's development.

In 1972, a Comprehensive Child Care Development Bill was passed by both the House and Senate in slightly different versions. These Bills included provisions for child advocacy. When the two versions went to the House-Senate Conference Committee, all mention of child advocacy was deleted. The revised version of the bill was later vetoed by President Nixon (Ross, 1972 (a) and (b)).

Contemporary Analysis of Child Mental Health

Congressional and Executive responses to JCMHC recommendations strongly suggest this is not an era in which major new kinds of institutions and institutional arrangements will be created. There shall be no grand new social orders in the present or near future. For those who are interested in large scale social responses to child mental health needs, the existing zeitgeist dictates a more conservative, or if you prefer, a more pragmatic approach. Improved child mental health in this era, will occur only through existing child-serving institutions.

In this regard, Sonis & Sonis (1975) speak of 'networks' in which children are 'captive'. They note that youth ages 6 to 19 years are captive within the school system. However, child mental health services have not actively provided services to children through the school network. For example, in 1972, NIMH and the Joint Information Service conducted a survey and found that only 14 of the 142 responding community mental health centers (CMHC) provided consultation to teachers and other school personnel (Glasscote et al., 1972, pp. 45-49).

Collaboration between CMHC's and public schools

In light of the crucial need for collaboration between the CMHC and the public school, a literature review was conducted of descriptions of their collaborative efforts. The review focused on literature published between 1970 through 1978. Descriptions of sufficient detail for analysis were found for 21 CMHC's.

In reporting and analyzing these descriptions, use is made of Robert Reiff's (1975) schema of levels of intervention. According to Reiff, intervention or collaboration may occur at one of five levels: individual, group, organization, community, and society. For purposes of this analysis, these levels are de-

fined as follows:

Individual: intervention/collaboration with an individual child teacher, or parent.

Group: intervention/collaboration with a group of teachers, or with a group of other personnel based at an individual school, or with a group of teachers and parents and/or children.

Organization or Institution: intervention/collaboration with all teachers based at an individual school, or with all personnel of a given classification throughout a school district (e.g. all principals, or all counselors), or with all children of a given classification within a school or neighborhood (e.g. all first graders), or with a school-based parent group concerned with issues impacting on the school's organization.

Community: Intervention/collaboration with a school district's top administrators or policy makers, or with a parent group representing several schools and concerned with neighborhood or district-wide issues.

Society: Intervention/collaboration with a state board or office of education, or with the U.S. Office of Education, or with a group of parents concerned with statewide issues.

An intervention/collaboration will also be defined as a process which occurs at prescribed intervals (at least once every month) and on a continual basis.

Reiff's schema also addresses intended levels of change. Change may occur at three levels: the individual, the situation or milieu, and the social structure. Use will also be made of this concept.

Individual intervention/collaboration. At this level, intervention/collaboration is generally either child-centered or teacher-centered. Child-centered interventions characteristically involve diagnosis through classroom

observation and/or testing, and treatment referral to the CMHC or some other community agency (Becker, 1971; Berlin, 1975; Glasscote et al., 1972, pp.169-192; Lee, 1977; Silver, 1977;Townsel, Irving & Stroo, 1975;Womack & Sata, 1975). Teacher-centered interventions generally involve collaboration with a teacher regarding management of an individual child's behavior. Such collaborations can be characterized as teacher-initiated or center initiated. Center-initiated collaboration occurs after a child has been seen at a CMHC(Glasscote et al., pp 53-76, 169-192;Silver, 1977). Teacher-initiated collaboration involves consultation regarding management of a 'problem child' (Glasscote et al., pp 104-146; Steinberg & Chandler, 1976;Sugerman, 1973; Townsel et al., 1975), or classroom climate (Pyle, 1977).

At this level of intervention/collaboration, change is generally anticipated at the individual level. As Hetznecker and Forman (1971) note, such interventions/collaborations represent an adaptation of the traditional child guidance clinic model, and do not represent new innovations in treatment. It is noteworthy that 14 of the 21 centers reviewed include some type of intervention/collaboration at this level.

Group intervention/collaboration. At this level,intervention focuses on training and education. Efforts typically involve training teachers regarding behavior and classroom management techniques, intra-organizational communication styles, principles of child development, identification of learning disorders, and special curricular needs. (Becker, 1971; Berlin, 1975; Glasscote et al., pp. 77-121, 169-192, 206-226; Lee, 1977; Mumford, 1971; Pyle, 1977; Steinberg & Chandler, 1976, Townsel et al., 1975). Thirteen CMHC's report involvement in such training and education activities.

Group intervention/collaboration also includes activities involving both children and teachers. Examples are: CMHC staff and school personnel serving as co-therapists for in-school children's group therapy sessions (Glasscote

et al., pp. 147-168); teachers, under CMHC staff supervision, meeting one hour per week with small groups of children having emotionally based learning problems (Pasnau, 1971); a joint CMHC-school staffing of a demonstration classroom for emotionally disturbed and mentally retarded youth(Steinberg & Chandler; Tharp, 1970);joint CMHC-school staffing of residential treatment programs (Lee; Sheare & Larson, 1978; Siver, 1977).

A third type of group intervention/collaboration involves the direct delivery of service to groups of children. Under this model, there is no teacher-training component. Services are delivered by CMHC staff either at the school or at the CMHC(Berlin, 1975; Sugarman, 1973; Townsel et al.; Womack & Sata, 1975).

Nineteen of the 21 centers reviewed engaged in intervention/collaboration at the level of the group. At this level, the anticipated level of change is generally dependent on whether one is a child or a teacher. If one is a teacher, collaboration focuses on broadening knowledge and increasing competency in managing behavioral and developmental problems. The training emphasis is not on meeting the specific needs of one child, but rather the general needs of all children encountered in the classroom. Reiff terms such an anticipated level of change as situational as it impacts upon the immediate milieu, that is the classroom and its climate. If one is a child, group intervention tends to involve some variation of group therapy and the primary anticipated level of change is the individual.

Organizational intervention/collaboration. At this level, intervention focusing on school personnel is exemplified in CMHC staff conducting weekly meetings with all high school counselors in a school district; monthly meetings with all of a district's school psychologists;regular in-service training of a school's teacher aides; consulting with a district's health educators regarding mental health curricular materials. (Glasscote et al., pp. 206-226;

Steinberg & Chandler; Townsel et al.) One CMHC reports that its' community advocates' formed five parent-school councils. These councils identified mental health and educational needs, and generally provided systematic feedback to school principals (Womack & Sata).

An example of child-centered intervention/collaboration is CMHC staffing of a multidisciplinary learning disability team which provides services for a Follow-Through program (Glasscote et al., pp. 53-76). Another CMHC reports that a team of its staff provides comprehensive services (even during the summer) to a class of 150 children from grade 1 through grade 3 (Mumford, 1971). CMHC staff also are used to screen all children entering kindergarten at two schools, and provide any indicated remedial services. (Becker, 1971).

At the organizational level, intervention/collaboration assumes more varied characteristics. For example, the intervention team often reflects greater professional diversity than the psychiatrist-psychologist-social worker team of the child guidance clinic model. Nonprofessionals are frequently included on these teams. At this level, the focus is exclusively on populations who are not identified as mentally ill or emotionally disturbed. Interventions tend to be more long-termed, with greater emphasis on continuity of service. The secondary prevention strategies of early identification and remediation are also emphasized. And psychotherapy is all but abandoned. Intervention/collaboration is directed toward change at the situational level. Only 7 of the 21 CMHC's reviewed engaged in school intervention/collaboration at the organization level.

Community intervention/collaboration. At this level, CMHC's collaborate with a school district's top administrators and/or policymakers, or with a parents' group concerned with impact more than an individual school. One CMHC reports it works closely with district administrators and policymakers in identifying

unmet mental health needs of school children, and planning needed services. In some cases, the CMHC has pilot-tested a service for a period of one year or less. Programmatic and administrative problems are identified and resolved and then the school district duplicates the thrust of the pilot program on a larger scale (Sugarman, 1973). Another CMHC formed a school- and neighborhood-based child advocacy board. This board successfully coordinated agencies and developed after-school, weekend and summer recreational programs for children and their families (Womack & Sata).

If these two examples are illustrative, mental health personnel engaging in community intervention/collaboration must be skilled in consultation, negotiation, and program planning and administration. Of course, such skills must be butressed by a firm grasp of child development and mental health principles. At this level, change is anticipated at the situational level, involving more than the individual classroom.

Reiff proposed a fifth level of intervention/collaboration. This was the societal level which has been defined as a CMHC's intervention/collaboration with a state board or department of education, or with the U.S. Office of Education. Collaboration at this level would probably impact on broad policy questions. No published reports were found of interventions at the societal level. Similarly, no descriptions were found in which the anticipated change would occur at the level of the social system.

In summary, the eight-year review of the literature reveals CMHC's generally collaborate with public schools at the level of either the individual or the group. The review also suggest that the level at which such intervention/collaboration occurs influences the type of intervention strategy, the skills required of CMHC personnel, the level of anticipated change, and the fundamental conceptualization of the service. The majority of centers continue to

conceptualize their child mental health services in terms of the traditional child guidance model.

Continuing social problems dictate that need and demand for child mental health services are increasing (JCMHC, 1970, pp. 184-185, 229,239, 415). Child services of CMHC's are typically responding to this reality by continuing in their traditional practices. Indeed, CMHC's resistance to engaging in more innovative collaborations is suggestive of their current institutional status.

Institutional predicaments

Institutions, like people, grow, develop and change. CMHC's are confronting internal crises similar to those experienced by most social services. They are under enormous conflicting external pressures to change. But in the name of 'professional identity' and the 'state of the art,' the most advanced ideas in the field are underutilized, while anachronistic, ineffectual methods are overutilized.

In reflecting on such crises, Brown (1977) has observed that CMHC's embody a potential for collision between social and clinical forces. Goldenberg (1971, pp. 96-98) notes that such crises often occur because young, helping institutions tend to assume they are 'healthier' than their clients, and not in need of their own services.

Resolution of crisis requires that we understand its constiuent predicaments. I believe there are five major predicaments confronting child services of CMHC's.

The ideological predicament: Personal troubles or social issues. Reiff (1975) makes the distinction between personal troubles and social issues. He notes that when the same personal trouble becomes evident in large numbers of persons throughout the society, that personal trouble is in fact a social issue. The personal trouble ideology is an outgrowth of the medical model view of the intrapsychic etiology of emotional distress. In contrast to this view,

Hetznecker and Forman (1971) note that community child psychiatry developed out of an awareness of social-cultural influences with special emphasis given to issues of social reform, race and poverty.

In intervention/collaboration with the school, the personal trouble and social issue predicament is exemplified in two competing concepts of the problem child: The problem resides solely within the child and his mode of interaction with significant others, or the problem involves deficits in the social structure in which the child finds himself.

The strategic predicament: Treatment or prevention. This predicament is symbionic to the ideological predicament. Imbued in the personal problem ideology is the individually focused strategy. Intervention involves treatment of individual deficiency. The typical strategy of choice is therapy (Adams, 1975; Goldmsith, 1973; Lewis, 1970). Similarly, the social issues ideology fosters emphasis on prevention strategies. Intervention focuses on social processes and institutions. The strategies of choice include planned change programs and consultation with key individuals and agencies (Rosenblum, 1969).

The unwillingness to resolve this predicament in ways mutually satisfying to all parties is somewhat tragic. As Goldenberg notes (1971, pp.42-49), the choice of a single treatment stategy serves to limit the problems and needs to be confronted.

The role predicament: Expert or generalist. Throughout this analysis, the term intervention/collaboration' has been used. Such terminology was not chosen because of significant technical differences between the two processes, but rather because of their connotative differences. Intervention has been a purview of the mental health consultant. Glasscote et al. (1972, p.36) notes that mental health consultation is based on the assumption the consultant, by

virtue of training and experience, has information and understanding of the consultee's problems that exceeds that of the consultee. Operating under such assumptions, the mental health consultant functions in the role of the 'expert'.

In contrast, the generalist possesses a wide repertoire of skills and competencies, only a few in which he might be considered expert. Consequently the generalist collaborates with an organization in an effort to mesh his competencies with those of persons within the organization. The generalist consultant is valuable to an orgaization because of the variety of approaches which he brings to bear upon the problem identification and resolution processes.

Expertness promotes greater functional distinctions among the helping professions. Goldenberg (1971, pp. 62-74) notes that when services are organized by areas of expertise, personnel tend to be evaluated more in terms of formal credentials rather than personal characteristics. This emphasis on professionalism tends to create a manpower shortage. It also promotes a narrow definition of role.

The power predicament: Professional perogatives or community imperatives. This predicament relates to issues of definition of problems and strategies, and planning and control of services. The key questions are: Who will engage in such processes? And how? Smith and Hobbs (1970) argue, a CMHC is an effective agency of the community only when its policy is controlled by the community. Under this circumstance, mental health professionals do not function as guardians of mental health, but as agents of the community.

An agency which views itself as a 'guardian of mental health' takes on a paternalistic mission and operates as a part of, yet apart from the community in which it is embedded (Goldenberg, 1971, pp. 113-114). Such an agency is in danger of developing a psychological gulf between itself and the community. The community increasingly perceives that the agency cannot meet its needs.

Agency and community become mutually estranged.

The personal predicament: Stability in tradition or ambiguity in change. An institution and its personnel are an interactive system. Consequently, when an institution experiences predicament, so do its personnel. Institutional processes diffuse to the individual level. (Murrell, 1973)

All of the previously discussed predicaments instigate the personal predicament regarding individuals' need for stability and tolerance for change. Institutional crisis can only be resolved when personal needs and demands of staff are sifted from those of the institution. Critical confrontation must occur on both levels.

Future Directions in Child Mental Health

If one accepts the proposition that change in child mental health services will occur only through existing child serving institutions, then one also can safely forecast that child mental health services will become more collaborative in character and less definable as a distinct service system. Institutional arrangements coupled with the pull of social needs and forces dictate that such a shift will occur regardless of any professional resistance (Brown, 1977).

The specific character of collaboration between a community's child mental health services and other child serving institutions can most effectively occur through a social and community systems approach. Thus the character of collaboration becomes dependent on such variables as socio-economic distribution of the target population; the size of that population; funding, facilities and personnel resources of both the CMHC and the institution(s) with which collaboration occurs; mental health needs and demands for services as perceived by both the target population and the collaborating institutions; availability and accessibility of other community services to meet such needs and demands; and the past effectiveness of the collaborating institutions.

Use of such a social and community systems approach could also be an intricate part of the process through which child mental health services of CMHC's work through their developmental crises and clarify alternatives.

The following are three prototypic models for delivery of CMHC child mental health services through collaboration with public schools. These models are grounded in social and community systems analysis. Of course, differences in local community characteristics would encourage multiple variations of these models.

The School-Based Model

This model would be most appropriate for large urban areas characterized by large numbers of low SES children in the schools; declining enrollment resulting in some excess of school physical facilities; declining property tax base reflected in increasing cutbacks of schools' auxillary services (including counseling and psychological services); high prevelance of poor academic achievement and school dropout; and availability of other community agencies to meet some of the needs of seriously disturbed children.

Under such conditions, there is a high demand for meeting the needs of seriously disturbed youth, but an even higher demand to meet the needs of the modal high risk child. CMHC collaboration could focus on secondary and primary prevention, with intervention occuring primarily at the levels of the community and organization. Child mental health workers, while employed by the local CMHC, could function on a day-to-day basis as though they were school employees. In such a dual role, administrative procedures, supervision and coordination of child mental health workers become paramount.

Adaptively-Based Model

This model is most appropriate for rural areas characterized by low population density, and difficulties in accessing a CMHC and other community services.Consequently there are equally high demands for services for both seriously

disturbed and high risk children.

Child mental health workers would function in a manner similar to that of agricultural extension agents. Time is divided equally between 'riding the circuit' of schools and the CMHC. At the schools, workers function in the dual role of expert consultant intervening at the organizational or group level, and diagnostic therapist. At the CMHC, workers function primarily in the role of therapist, and directly deliver various diagnostic, rehabilitative and therapeutic services.

Clinic-Based Model

This model can be effectively utilized in collaborating with suburban schools characterized by a low proportion of low SES children; limited community services which are nonetheless readily accessed by the target population; a sufficient property tax base for schools reflected in maintenance and possible expansion of school auxillary service; moderate to high academic achievement; relatively low rates of school dropout; and a stable or increasing school population.

Under such conditions, schools are making notable efforts to meet the instructional and mental health needs of high risk children. The pressing needs are those related to more seriously disturbed children. Mental health workers serve as expert consultants to individual teachers and occassionally provide more general consutlation. However the bulk of effort is devoted to intervention on the individual and group level. The mental health worker functions primarily as a therapist/diagnostician, delivering the bulk of services within the setting of the CMHC.

These three models indicate various strategies through which CMHC's might capitalize upon collaboration with schools guided by social and community systmes analysis. Failure to effect such collaboration reflects professional and institutional inability to cope with developmental crises. The challenge is for

professionals and CMHC's to be the target of their own services and skills. As individuals and institutions, we must look into the mirror of our past and present selves and employ that encounter as a basis for growth, change, and renewal.

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